

septic infection. Hysterectomy was performed as rapidly as possible. A stump of the cervix was left in the lower angle of the abdominal wound. The peritoneal incision was closed except at the lower angle, where a strip of iodoform gauze was passed down into the cul-de-sac. The patient was difficult to manage, refusing food, irrational and developing incontinence of the bladder and rectum, with beginning bed-sores. These were treated most successfully by exposing the tissues about them to the sunlight daily for several hours. There was a profuse genital discharge which persisted for some time. Thrombophlebitis of the left leg developed, but the patient gradually recovered and left the hospital in very fair condition. Examination of the material removed showed infection with the *Bacillus coli communis*. In discussing this paper several cases were reported of fatalities complicating pregnancy in which infection and sloughing developed. These cases were saved by hysterectomy, but it was thought that the operation should be done as early as possible.

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**The Technic of Salpingectomy in Ectopic Gestation.**—CAREY (*Am. Jour. Obst.*, March, 1919) reports the case of a patient, aged thirty-nine years, admitted to the hospital with symptoms of ruptured ectopic pregnancy. At operation the left broad ligament was very much swollen, edematous and friable, and the tube was in the same condition. Abortion had taken place from the fimbriated end of the tube. The operator attempted to save a part of the tube and removed the outer half, leaving the ovary. After the patient's recovery she came for examination, when it was found there was a small, fixed, moderately tender mass on the left side of the uterus. The patient had a retroverted, prolapsed uterus, with old lacerations and cystocele, and on opening the abdomen the sigmoid and omentum were adherent in the region of the left tube and ovary, the part of the tube which had been left was atrophic and closed and the ovary had been replaced by a cyst a little larger than a golf-ball. The cyst was removed, the raw surface covered over and the uterus fixed to the anterior abdominal wall. The patient made a good recovery. The writer cites this case as illustrating the failure of his attempt to preserve a portion of the tube. He believes that a much better result would have been obtained had both tube and ovary been removed entire.

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**Contra-indications to the Use of Dilating Bags.**—HULL (*Am. Jour. Obst.*, March, 1919) calls attention to several important contra-indications to the use of dilating bags. Before introducing the bag the operator should be sure that the cervix can be dilated and that there is good reason for believing that labor pains will develop. He must be on his guard against a rigid cervix and primary uterine inertia. In two cases the use of bags failed, although continuous traction was made with a two-pound weight. It was necessary to deliver these patients by vaginal Cesarean section. Bags were also contra-indicated when great haste is necessary, as in severe accidental hemorrhage, threatened edema of the lungs and tightly contracted uterus or failure in cardiac compensation. In contracted pelvis with a true conjugate of less than 8 cm. the use of bags should not be permitted. In borderland cases induction of labor has been abandoned by the writer. He prefers to put the patient in the best possible condition and to give her the trial of labor,

watching closely the condition of mother and child. The results of induced labor in contracted pelvis are so much inferior to those of spontaneous labor or Cesarean section that induced labor should rarely be done. In complete placenta previa with viable child, section should be employed instead of the use of the bag. Virulent infection of the genital organs should contra-indicate the use of the bag. As regards normal cases at term it is difficult to find a good excuse for interference by the use of dilating bags. There is no way of determining the proper time for this operation, and the complications which may accompany the use of bags are sufficiently important to be avoided. When dystocia lies in the soft parts it is often preached that the bag is the ideal method of treatment. It is true that complete dilatation cannot be obtained, for the bag cannot imitate or set up the normal action of the uterus. The cervix is never completely dilated under the use of the bag alone. While it is true there are certain conditions in which the bag acts properly, its use has been greatly overdone, and it does not give the best results in many cases.

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**Cerebral Hemorrhage Complicating Pregnancy.**—LANGROCK (*Am. Jour. Obst.*, March, 1919) describes the case of a primipara, aged twenty-three years, who had been feeling well until she had a convulsion and became unconscious, and up to the time of her admission to the hospital did not regain consciousness. The diagnosis of eclampsia had been made, and on admission the blood-pressure was 180 and the pulse 54. The patient had Cheyne-Stokes breathing and the respirations were very shallow. Only a few drops of highly colored urine were obtained by catheter. There was slight edema of the lungs, more marked of the ankles. The whole right side of the body was exceedingly spastic, and this was also true of the left lower extremity. The neck was slightly rigid, the left pupil widely dilated, the right contracted to a pin-point and neither reacted to light, nor was there corneal reflex. Babinski's sign was present on both sides, with exaggerated knee-jerks. There were moist rales through the lungs, while the heart sounds were feeble and very irregular. On abdominal examination the uterus was eight and one-half months; the head was freely movable above the pelvis. The fetal heart was heard very plainly in the left lower quadrant, beating 148 times to the minute. On vaginal examination the cervix admitted two fingers, and was soft and thin. Lumbar puncture was exceedingly difficult and only a few cubic centimeters of bloody fluid was obtained. The patient was not in labor, although the cervix showed two fingers' dilatation and was soft and thin. The diagnosis lay between eclampsia and intracranial pressure, and the latter seemed probable because of the unequal pupils, which did not react; slow pulse, Cheyne-Stokes breathing, spastic contraction of muscles and the Babinski reflex. The intracranial pressure was thought to be due to cerebral hemorrhage from eclampsia, injury to the cranium during her fall to the floor following the first convulsion or cerebral hemorrhage from a rupture of the bloodvessel, the seat of syphilitic endarteritis. At the moment of the patient's death, postmortem Cesarean section was done, and a child weighing six pounds and fourteen ounces, vigorous and in good condition, was delivered. The patient lived but a short time, dying from failure of the action of the heart, with profound cyanosis.